



Serving the People Who Serve Our Schools

# Welcome to SERS

Established by state law in 1937, SERS is one of five Ohio public pension funds and provides retirement, disability, survivor, and other benefits to its eligible members, retirees, and beneficiaries. The retirement plan SERS offers is a **defined benefit (DB)** plan. Under a DB plan, the amount of a person's retirement allowance is a fixed lifetime benefit.

**Working Together to Build Your Secure Retirement** SERS funds the benefits it provides from three sources: member contributions (you make your member contributions through your employer), employer contributions, and investment earnings. Earnings on SERS' investments are the major source of SERS' assets. The System provides retirement benefits to more than 63,000 retired members. You are joining more than 123,000 current, active members.

**Ensuring Funds Will Be Available When You Retire** SERS takes very seriously its mission to provide pensions, benefits, and services to our members, retirees, and beneficiaries that are soundly financed, prudently administered, and delivered with understanding and responsiveness.

## **SERS' Member Publications and Website Keep You Connected**

Soon you will receive your *Member Handbook* in the mail. It contains detailed information about your retirement plan and benefits. Also, please make sure to read the quarterly publications that SERS will mail to your home address. It is important that you keep your address current with SERS.

Please visit our website at [www.ohsers.org](http://www.ohsers.org) for comprehensive benefit information and the latest SERS news. You can use the website's Member Log-in feature to safely access your personal account and updated contribution balance.

## **SERS' Benefits Available to You**

**Your Member Contributions** You are **guaranteed** the return of your member contributions in the form of a retirement allowance, survivor benefit, or refund. Your right to receive a retirement allowance becomes guaranteed when your retirement application is approved. Instead of a retirement allowance, you may receive a refund of your member contributions if you stop working for your SERS employer. However, if you take a refund, you give up all of your SERS membership rights including the right to receive a retirement allowance, and tax penalties will apply unless you roll the money into a qualified account. For more information, see your *Member Handbook*.

**Your Retirement Benefits** Your retirement allowance is based on your age, number of years of service ("service credit"), and final average salary (FAS). For more information, see your *Member Handbook*.

A member who joins SERS before **May 14, 2008** will be eligible for a guaranteed lifetime monthly pension with the following combinations of age and service credit:

- 5 years of service credit at age 60; or
- 25 years of service credit at age 55; or
- 30 years of service credit at any age.

Those who become SERS members **on or after May 14, 2008** will be eligible for a guaranteed lifetime monthly pension with the following combinations:

- 10 years of service credit at age 62; or
- 25 years of service credit at age 60; or
- 30 years of service credit at age 55.

**Disability Benefits** If you become physically or mentally unable to perform the duties of your school job, and you have at least five years of service credit, you can apply for disability benefits. If approved, your benefit amount will range from 45% to 60% of your final average salary (FAS). For more information, see your *Member Handbook*.

**Survivor Benefits** Monthly survivor benefits are payable to qualified beneficiaries of a member who dies before retirement. Qualified beneficiaries who are receiving a monthly survivor benefit also have access to SERS health care plan.

Also, upon the death of a disability or service retiree, a \$1,000 lump sum death benefit is paid to the designated beneficiary. For more Survivor Benefit information, see your *Member Handbook*.

**Health Insurance** SERS has provided retirees with access to health insurance since 1974, and it is the goal of the retirement system to continue this access. Plan benefits, premiums, and continued access depend upon available resources and are subject to change.

**Members should be aware, however, that health insurance is not guaranteed. Unlike pensions, which are required by Ohio law, health insurance is provided at the discretion of SERS' Retirement Board and the available plans can change at any time.** For more information, see your *Member Handbook*.

SERS is your partner in helping you achieve a secure retirement. Our staff is here to help you, so please don't hesitate to contact us toll free at 1-866-280-7377 if you have any questions or would like to schedule a retirement counseling session.



# SCHOOL EMPLOYEES RETIREMENT SYSTEM OF OHIO

300 EAST BROAD ST., SUITE 100 • COLUMBUS, OHIO 43215-3746 • (614) 222-5853  
Toll-Free 1-866-280-7377 • www.ohsers.org

## Membership Record

### PART A - TO BE COMPLETED BY MEMBER

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SOCIAL SECURITY NUMBER

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE \_\_\_\_\_ MAIDEN \_\_\_\_\_

PERMANENT MAILING ADDRESS \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
MALE  FEMALE

DATE OF BIRTH \_\_\_\_\_ MONTH \_\_\_\_\_ DAY \_\_\_\_\_ YEAR \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_  
SINGLE  MARRIED  DIVORCED  WIDOWED

PHONE NUMBER ( ) \_\_\_\_\_

### FAMILY DATA

SPOUSE \_\_\_\_\_ LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE OR MAIDEN \_\_\_\_\_ DATE OF BIRTH MONTH/DAY/YEAR \_\_\_\_\_

CHILDREN \_\_\_\_\_

FATHER \_\_\_\_\_

MOTHER \_\_\_\_\_

### JOB CLASSIFICATION *Mark one box only:*

- Administrative
- Educational Aide
- Supplemental (Coach, Advisor, Etc.)
- Clerical/Secretarial
- Food Service
- School Board Member
- Custodial/Maintenance
- Transportation
- Other \_\_\_\_\_

### MEMBERSHIP IN OTHER OHIO SYSTEM

For all of the following, check "yes" or "no" if you ever were a member of or received benefits from:

	MEMBER		BENEFIT	
School Employees Retirement System of Ohio	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
State Teachers Retirement System of Ohio	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Ohio Public Employees Retirement System	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Ohio Police and Fire Pension Fund	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Ohio State Highway Patrol Retirement System	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cincinnati Municipal Retirement System	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO

### MEMBER CERTIFICATION

I hereby certify the information given hereon to be true to the best of my knowledge.

SIGNATURE \_\_\_\_\_ DO NOT PRINT \_\_\_\_\_ DATE \_\_\_\_\_

### PART B - TO BE COMPLETED BY EMPLOYER

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SCHOOL DISTRICT \_\_\_\_\_ COUNTY \_\_\_\_\_ COUNTY \_\_\_\_\_ DISTRICT NO. \_\_\_\_\_  
MEMBER'S FIRST DATE OF SERVICE THIS SCHOOL YEAR (July 1 - June 30) \_\_\_\_\_

I hereby certify that I have verified the employee's social security number, the job title, and the first date of service for the current employment.

TREASURER'S SIGNATURE \_\_\_\_\_

**Statement Concerning Your Employment in a Job  
Not Covered by Social Security**

Employee Name

Employee ID#  
(Social Security #)

Employer Name

Employer ID#

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

**Windfall Elimination Provision**

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is \$313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

**Government Pension Offset Provision**

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of \$600 based on earnings that are not covered under Social Security, two-thirds of that amount, \$400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a \$500 widow(er) benefit, you will receive \$100 per month from Social Security (\$500 - \$400=\$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

**For More Information**

Social Security publications and additional information, including information about exceptions to each provision, are available at [www.socialsecurity.gov](http://www.socialsecurity.gov). You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

**I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security benefits.**

Signature of Employee

Date

# Certification Renewal



Educational Service Center  
Of Lorain County  
1885 Lake Avenue  
Elyria, Ohio 44035  
Phone: (440) 324-5777  
(440) 244-1659  
Fax: (440) 324-7355

## CRIMINAL HISTORY INFORMATION

- \_\_\_\_\_ OHIO ONLY - \$23.00
- \_\_\_\_\_ OHIO & FBI - \$47.00
- \_\_\_\_\_ FBI ONLY - \$32.00
- \_\_\_\_\_ OBTAINING A NEW CERTIFICATE

## HOURS:

Monday 9:00 - 11:00  
Wednesday 9:00-10:30 & 1:30-4:00  
Thursday 9:00 - 11:00

## APPOINTMENTS REQUIRED

*(Please call if you need to cancel)*

Contact: 440-324-5777 or 440-244-1659 to schedule

Any Questions or if you need a special time to come in  
Please Contact Pam at (440) 324-5777, ext. 1113

**\*\*Remember To Moisturize Your Hands Before Appointment**

### Items Needed at Appointment:

1. This Completed Form
2. Driver's License or State ID Card
3. Cash/Check/Money Order or billing form

### PLEASE TYPE OR PRINT THE FOLLOWING:

NAME: \_\_\_\_\_  
(Last) (First) (Middle)

COMPLETE ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

I understand that, if the release is statutorily required as a condition of employment, or being a volunteer, The Educational Service Center of Lorain County will be provided with any additional arrest or conviction record pertaining to me entered into the files of the Bureau of Criminal Identification or Investigation for a period of one (1) year following the date of the execution of this release. I hereby release the Ohio Bureau of Criminal Identification and Investigation, The Educational Service Center of Lorain County, and all individuals connected therewith from all liability in connection with the dissemination of such arrest and conviction data.

Signature: \_\_\_\_\_ Date \_\_\_\_\_



Ohio Department of Public Safety
Division of Homeland Security
http://www.homelandsecurity.ohio.gov

PUBLIC EMPLOYMENT

In accordance with section 2909.34 of the Ohio Revised Code

DECLARATION REGARDING MATERIAL ASSISTANCE/NONASSISTANCE TO A TERRORIST ORGANIZATION

This form serves as a declaration of the provision of material assistance to a terrorist organization or organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List (see the Ohio Homeland Security Division website for a reference copy of the Terrorist Exclusion List).

Any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided. Failure to disclose the provision of material assistance to such an organization or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree.

For the purposes of this declaration, "material support or resources" means currency, payment instruments, other financial securities, funds, transfer of funds, and financial services that are in excess of one hundred dollars, as well as communications, lodging, training, safe houses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives, personnel, transportation, and other physical assets, except medicine or religious materials.

Form with fields: LAST NAME, FIRST NAME, MIDDLE INITIAL, HOME ADDRESS, CITY, STATE, ZIP, COUNTY, HOME PHONE, WORK PHONE

DECLARATION

In accordance with division (A)(2)(b) of section 2909.32 of the Ohio Revised Code

For each question, indicate either "yes," or "no" in the space provided. Responses must be truthful to the best of your knowledge.

- 1. Are you a member of an organization on the U.S. Department of State Terrorist Exclusion List?
2. Have you used any position of prominence you have with any country to persuade others to support an organization on the U.S. Department of State Terrorist Exclusion List?
3. Have you knowingly solicited funds or other things of value for an organization on the U.S. Department of State Terrorist Exclusion List?

PUBLIC EMPLOYMENT - CONTINUED

4. Have you solicited any individual for membership in an organization on the U.S. Department of State Terrorist Exclusion List?  
 Yes  No
5. Have you committed an act that you know, or reasonably should have known, affords "material support or resources" to an organization on the U.S. Department of State Terrorist Exclusion List?  
 Yes  No
6. Have you hired or compensated a person you knew to be a member of an organization on the U.S. Department of State Terrorist Exclusion List, or a person you knew to be engaged in planning, assisting, or carrying out an act of terrorism?  
 Yes  No

In the event of a denial of public employment due to a positive indication that material assistance has been provided to a terrorist organization, or an organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List, a review of the denial may be requested. The request must be sent to the Ohio Department of Public Safety's Division of Homeland Security. The request forms and instructions for filing can be found on the Ohio Homeland Security Division website.

**CERTIFICATION**

I hereby certify that the answers I have made to all of the questions on this declaration are true to the best of my knowledge. I understand that if this declaration is not completed in its entirety, it will not be processed and I will be automatically disqualified. I understand that I am responsible for the correctness of this declaration. I understand that failure to disclose the provision of material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List, or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree. I understand that any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided by myself or my organization.

X

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Employment Eligibility Verification

Please read instructions carefully before completing this form. The instructions must be available during completion of this form. **ANTI-DISCRIMINATION NOTICE:** It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

**Section 1. Employee Information and Verification.** To be completed and signed by employee at the time employment begins.

Print Name: Last	First	Middle Initial	Maiden Name
Address (Street Name and Number)		Apt. #	Date of Birth (month/day/year)
City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- A citizen or national of the United States
- A Lawful Permanent Resident (Alien #) A \_\_\_\_\_
- An alien authorized to work until \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Alien # or Admission #) \_\_\_\_\_

Employee's Signature	Date (month/day/year)
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**Preparer and/or Translator Certification.** (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer's/Translator's Signature	Print Name
Address (Street Name and Number, City, State, Zip Code)	
Date (month/day/year)	

**Section 2. Employer Review and Verification.** To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number and expiration date, if any, of the document(s).

List A	OR	List B	AND	List C
Document title: _____		_____		_____
Issuing authority: _____		_____		_____
Document #: _____		_____		_____
Expiration Date (if any): ____/____/____		____/____/____		____/____/____
Document #: _____		_____		_____
Expiration Date (if any): ____/____/____		____/____/____		____/____/____

**CERTIFICATION** - I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) \_\_\_\_/\_\_\_\_/\_\_\_\_ and that to the best of my knowledge the employee is eligible to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name		Date (month/day/year)
Address (Street Name and Number, City, State, Zip Code)		

**Section 3. Updating and Reverification.** To be completed and signed by employer.

A. New Name (if applicable)	B. Date of rehire (month/day/year) (if applicable)
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C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment eligibility.

Document Title: \_\_\_\_\_ Document #: \_\_\_\_\_ Expiration Date (if any): \_\_\_\_/\_\_\_\_/\_\_\_\_

I attest, under penalty of perjury, that to the best of my knowledge, this employee is eligible to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date (month/day/year)
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NOTE: This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

## Employment Eligibility Verification

### INSTRUCTIONS

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM.

**Anti-Discrimination Notice.** It is illegal to discriminate against any individual (other than an alien not authorized to work in the U.S.) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work eligible individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because of a future expiration date may also constitute illegal discrimination.

**Section 1 - Employee.** All employees, citizens and noncitizens, hired after November 6, 1986, must complete Section 1 of this form at the time of hire, which is the actual beginning of employment. **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

**Preparer/Translator Certification.** The Preparer/Translator Certification must be completed if Section 1 is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete Section 1 on his/her own. However, the employee must still sign Section 1 personally.

**Section 2 - Employer.** For the purpose of completing this form, the term "employer" includes those recruiters and referrers for a fee who are agricultural associations, agricultural employers or farm labor contractors.

Employers must complete Section 2 by examining evidence of identity and employment eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, Section 2 must be completed at the time employment begins. **Employers must record:** 1) document title; 2) issuing authority; 3) document number, 4) expiration date, if any; and 5) the date employment begins. Employers must sign and date the certification. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the I-9. However, employers are still responsible for completing the I-9.

**Section 3 - Updating and Reverification.** Employers must complete Section 3 when updating and/or reverifying the I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in Section 1. Employers **CANNOT** specify which document(s) they will accept from an employee.

- If an employee's name has changed at the time this form is being updated/reverified, complete Block A.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee is still eligible to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.
- If an employee is rehired within three (3) years of the date this form was originally completed and the employee's work authorization has expired or if a current employee's work authorization is about to expire (reverification), complete Block B and:

- examine any document that reflects that the employee is authorized to work in the U.S. (see List A or C),
- record the document title, document number and expiration date (if any) in Block C, and
- complete the signature block.

**Photocopying and Retaining Form I-9.** A blank I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed I-9s for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

For more detailed information, you may refer to the Department of Homeland Security (DHS) Handbook for Employers, (Form M-274). You may obtain the handbook at your local U.S. Citizenship and Immigration Services (USCIS) office.

**Privacy Act Notice.** The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by officials of the U.S. Immigration and Customs Enforcement, Department of Labor and Office of Special Counsel for Immigration Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

**Reporting Burden.** We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: 1) learning about this form, 5 minutes; 2) completing the form, 5 minutes; and 3) assembling and filing (recordkeeping) the form, 5 minutes, for an average of 15 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., Washington, DC 20529. OMB No. 1615-0047.

**NOTE:** This is the 1991 edition of the Form I-9 that has been rebranded with a current printing date to reflect the recent transition from the INS to DHS and its components.

### Ohio New Hire Reporting

Ohio Revised Code section 3121.89 to 3121.8910 requires all Ohio employers, both public and private, to report all contractors and newly hired, rehired, or returning to work employees to the state of Ohio within 20 days of the contract, hire, or rehire date. Information about new hire reporting and online reporting is available on our website: [www.oh-newhire.com](http://www.oh-newhire.com)

Send completed forms to:  
Ohio New Hire Reporting Center  
PO Box 15309  
Columbus, OH 43215-0309  
Fax: (614) 221-7088 or toll-free fax (888) 872-1611

To ensure the highest level of accuracy, please print neatly in capital letters and avoid contact with the edges of the boxes. The following will serve as an example:

A B C      1 2 3

#### EMPLOYER INFORMATION

Federal Employer ID Number (FEIN) (Please use the same FEIN as the listed employee's quarterly wages will be reported under):

Employer Name:

Employer Address (Please indicate the address where the Income Withholding Orders should be sent).

Employer City:      Employer State:      Zip Code (5 digit):

Employer Phone (optional):      Extension:      Employer Fax (optional):

Email:     

#### EMPLOYEE OR CONTRACTOR INFORMATION

Social Security Number (SSN)       (Check here if using FEIN for the Contractor)

State of Hire:     

First Name:      Middle Initial:     

Last Name:     

Address:     

City:      State:      Zip Code (5 digit):

Date of Hire:      Date of Birth:      Is this a Contractor?

Date payments will begin for Contractor:      Length of time the Contractor will be performing services:

REPORTS WILL NOT BE PROCESSED IF REQUIRED INFORMATION IS MISSING

# Form W-4 (2010)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2010 expires February 16, 2011. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** You cannot claim exemption from withholding if (a) your income exceeds \$950 and includes more than \$300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on his or her tax return.

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax

payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

**Nonresident alien.** If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2010. See Pub. 919, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

## Personal Allowances Worksheet (Keep for your records.)

<b>A</b> Enter "1" for yourself if no one else can claim you as a dependent . . . . .	<b>A</b> _____
<b>B</b> Enter "1" if: <ul style="list-style-type: none"> <li>• You are single and have only one job; or</li> <li>• You are married, have only one job, and your spouse does not work; or</li> <li>• Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less.</li> </ul>	<b>B</b> _____
<b>C</b> Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . .	<b>C</b> _____
<b>D</b> Enter number of dependents (other than your spouse or yourself) you will claim on your tax return . . . . .	<b>D</b> _____
<b>E</b> Enter "1" if you will file as head of household on your tax return (see conditions under <b>Head of household</b> above) . . . . .	<b>E</b> _____
<b>F</b> Enter "1" if you have at least \$1,800 of child or dependent care expenses for which you plan to claim a credit . . . . .	<b>F</b> _____
<b>(Note.</b> Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	
<b>G</b> <b>Child Tax Credit</b> (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. <ul style="list-style-type: none"> <li>• If your total income will be less than \$61,000 (\$90,000 if married), enter "2" for each eligible child; then less "1" if you have three or more eligible children.</li> <li>• If your total income will be between \$61,000 and \$84,000 (\$90,000 and \$119,000 if married), enter "1" for each eligible child plus "1" additional if you have six or more eligible children.</li> </ul>	<b>G</b> _____
<b>H</b> Add lines A through G and enter total here. <b>(Note.</b> This may be different from the number of exemptions you claim on your tax return.) ▶	<b>H</b> _____
For accuracy, complete all worksheets that apply. <ul style="list-style-type: none"> <li>• If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the <b>Deductions and Adjustments Worksheet</b> on page 2.</li> <li>• If you have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$18,000 (\$32,000 if married), see the <b>Two-Earners/Multiple Jobs Worksheet</b> on page 2 to avoid having too little tax withheld.</li> <li>• If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.</li> </ul>	

----- Cut here and give Form W-4 to your employer. Keep the top part for your records. -----

Form <b>W-4</b> Department of the Treasury Internal Revenue Service	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="font-size: small; margin: 0;">▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.</p>	OMB No. 1545-0074  <h1 style="margin: 0;">2010</h1>
1 Type or print your first name and middle initial. Last name		2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2010, and I certify that I meet both of the following conditions for exemption. <ul style="list-style-type: none"> <li>• Last year I had a refund of all federal income tax withheld because I had no tax liability and</li> <li>• This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.</li> </ul> If you meet both conditions, write "Exempt" here . . . . . ▶		7 _____
Under penalties of perjury, I declare that I have examined this certificate and to the best of my knowledge and belief, it is true, correct, and complete.		
Employee's signature (Form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)		9 Office code (optional) 10 Employer identification number (EIN)

### Notice to Employee

1. For state purposes, an individual may claim only natural dependency exemptions. This includes the taxpayer, spouse and each dependent. Dependents are the same as defined in the Internal Revenue Code and as claimed in the taxpayer's federal income tax return for the taxable year, or which the taxpayer would have been permitted to claim had the taxpayer filed such a return.

2. You may file a new certificate at any time if the number of your exemptions **increases**.

You must file a new certificate within 10 days if the number of exemptions previously claimed by you **decreases** because:

- Your spouse for whom you have been claiming exemption is divorced or legally separated, or claims her (or his) own exemption on a separate certificate.
- The support of a dependent for whom you claimed exemption is taken over by someone else.
- You find that a dependent for whom you claimed exemption must be dropped for federal purposes.

The death of a spouse or a dependent does not affect your withholding until the next year but requires the filing of a new

certificate. If possible, file a new certificate by Dec. 1st of the year in which the death occurs.

For further information, consult the Ohio Department of Taxation, Income Tax Division, or your employer.

3. If you expect to owe more Ohio income tax than will be withheld, you may claim a smaller number of exemptions; or under an agreement with your employer, you may have an additional amount withheld each pay period.

4. A married couple with both spouses working and filing a joint return will, in many cases, be required to file an individual estimated income tax form IT 1040ES even though Ohio income tax is being withheld from their wages. This result may occur because the tax on their combined income will be greater than the sum of the taxes withheld from the husband's wages and the wife's wages. This requirement to file an individual estimated income tax form IT 1040ES may also apply to an individual who has two jobs, both of which are subject to withholding. In lieu of filing the individual estimated income tax form IT 1040ES, the individual may provide for additional withholding with his employer by using line 5.

✂ please detach here



Ohio Department of  
**TAXATION**

### Employee's Withholding Exemption Certificate

IT 4  
Rev. 12/05

Print full name \_\_\_\_\_ Social security number \_\_\_\_\_

Home address and ZIP code \_\_\_\_\_

Public school district of residence \_\_\_\_\_ School district no. \_\_\_\_\_  
(See *The Finder* at tax.ohio.gov.)

1. Personal exemption for yourself, enter "1" if claimed \_\_\_\_\_

2. If married, personal exemption for your spouse if not separately claimed (enter "1" if claimed) \_\_\_\_\_

3. Exemptions for dependents \_\_\_\_\_

4. Add the exemptions that you have claimed above and enter total \_\_\_\_\_

5. Additional withholding per pay period under agreement with employer \_\_\_\_\_ \$

Under the penalties of perjury, I certify that the number of exemptions claimed on this certificate does not exceed the number to which I am entitled.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## MIDVIEW LOCAL SCHOOLS DIRECT DEPOSIT AUTHORIZATION FORM

I hereby authorize the MIDVIEW LOCAL SCHOOL DISTRICT and the depository financial institution name below, to initiate credit entries to the account(s) listed below. I authorize the MIDVIEW LOCAL SCHOOL DISTRICT to initiate debit entries if necessary to adjust for any credit entries made in error to the account(s) listed below. The DEPOSITORY listed below shall accept these credit and / or debit entries to my account(s).

**IMPORTANT:** If the Credits / Debits are to be made to a Checking Account, please attach a copy of your check to this form (You can bring in your check to the Treasurer's Office and they can copy it for you).

**IMPORTANT:** If the Credits / Debits are to be made to a Savings Account, please attach one of your deposit slips to this form.

FINANCIAL INSTITUTION Bank Name and Branch Location	Routing Number	Account Number	(C)hecking or (S)avings	Percentage or Dollar Amt.

**GO PAPERLESS:** Midview Local Schools now offers paperless pay receipts. You have the option to receive your pay stub via email. *There is no confidential information on this email.* Please provide us with an email address that you wish to have this sent to.

Email Address

This is to remain in full force and effect until MIDVIEW LOCAL SCHOOLS has received written notification from me of its termination in such time and manner as to afford Midview and Depository a reasonable opportunity to act on it.

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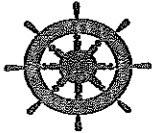
Employee Name - Please print

---

Employee Authorization Signature

---

Date



# MIDVIEW LOCAL SCHOOL DISTRICT

## EMPLOYEE'S SCHOOL DISTRICT INCOME TAX FORM

With the passage of SB28 which allows school districts to put an income tax for schools on the ballot, it is the responsibility of each employer to request that each employee furnish the name and number of the school district in which they reside. The four-digit number can be found in the instruction booklet for Ohio taxes.

Please list below the school district in which you **RESIDE** and its number.

\_\_\_\_\_  
School District Name

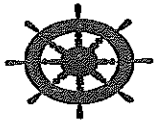
\_\_\_\_\_  
School District Number

Name \_\_\_\_\_  
*Please print*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_



# MIDVIEW LOCAL SCHOOL DISTRICT

## EMPLOYEE'S WITHHOLDING CERTIFICATE CITY INCOME TAX

All employees living or working within the corporate limits of a municipality having an income tax are subject to withholding.

Name \_\_\_\_\_  
*Please print*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

Social Security # \_\_\_\_\_

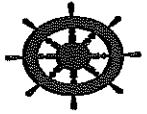
Is the above address within corporate limits subject to city income tax?  
(If you are unsure, contact your community's local income tax office.)

YES \_\_\_\_\_ NO \_\_\_\_\_

If **YES**, give percentage \_\_\_\_\_ %

If **NO**, name the township where address is located \_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_



**MIDVIEW LOCAL SCHOOL DISTRICT**  
**HEALTH INFORMATION CARD**

Date \_\_\_\_\_

School Year \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Position \_\_\_\_\_ Grade Level \_\_\_\_\_

School \_\_\_\_\_

**Emergency Contact Information**

**Main Contact**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

1st Number \_\_\_\_\_

2nd Number \_\_\_\_\_

Family Doctor \_\_\_\_\_

Phone \_\_\_\_\_

Office Location \_\_\_\_\_

Please list any disabilities, allergies, or unusual illnesses

\_\_\_\_\_  
\_\_\_\_\_

Is there anyone that should not be notified in case of emergency?

Name \_\_\_\_\_

Number \_\_\_\_\_